3. HEALTH EDUCATION TECHNIQUES

3.1 QUESTION-AND-ANSWER
EXPLANATION AND MEANING

Questions are often asked to try and involve people; but for this to work, the right type of question needs to be asked in the right way.

There are several different types of questions. One useful classification of types of questions is between open and closed questions:

Closed questions are ones in which the number of answers is limited. For example:
- questions to which the answer is "yes" or "no".
- questions which give an "either/or" choice.

Closed questions should generally be avoided in health education as people tend to guess the answer (or guess what they think the health educator wants for the answer).

Open questions are ones in which the number of answers is not limited. For example:
- questions beginning with why/how/what/when.
- questions that ask for peoples' feelings, opinions, suggestions, or descriptions.

Open questions generally produce far more information than closed questions.

Reasons for using

There are several different ways in which questions can be used:

1. Genuine questions asked by learners
The health educator gives a presentation and then invites the audience to ask questions, i.e. the learners ask and the teacher answers. This is the most genuine and important use of questions, because it means the health educator is giving people information they really want.

This kind of question-and-answer session can be very valuable. The opportunity for this type of question should always be provided in one-to-one and small-group situations, and also at the end of health talks and other kinds of presentation to large groups.

If the health educator considers that other participants are likely to know the answer to a question then he/she may direct the question back to the participants.

2. <u>Genuine questions asked by teachers</u>

The health educator asks questions to find out about people's existing knowledge, attitudes and practices. She/He listens carefully and respectfully to all answers. This is another important use of question and answer, because it gives the health educator information about health beliefs and practices in the community. This information is valuable in deciding which topics/messages are most important for the Health Education programme.

Genuine questions are also useful to find out what people already know, so that the health educator can build on their existing knowledge, and not waste time and bore people by telling them things they already know.

Examples of this type of question would be:
- What has your baby eaten today?
- What do you usually feed him?

3. <u>Testing questions</u>
The health educator asks questions in order to find out whether or not people know the answers. This use of questions is fundamentally different from uses 1 & 2 because in this case the educator only asks questions to which He/She already knows the answer. This is a completely different use of questions from their use by ordinary people. However, such questions are useful tools for assessing how much has been learnt. This in turn provides useful feedback for teachers on how effective their teaching was. This type of question must be used carefully and diplomatically so that the students do not feel embarrassed if they have not understood; it may be because the teaching was inadequate.

Examples of testing questions would be - after a health education session about vaccination - asking: why is vaccination important? Who needs to be vaccinated? What diseases can vaccines prevent?

4. <u>Teaching questions</u>

The health educator uses questions to encourage people to engage in a discussion which he/she leads. In this way the health educator can guide people towards saying the things he/she wants to hear in order to reach the conclusion which the health educator wants. Teaching questions are often used to try and involve people in the health education session. However, skill, tact and self-restraint are all needed to use teaching questions well.

An example of this use of questions would be:
If you are outside a house, where are you likely to find a lot of flies?
- Rubbish heaps, dung heaps, faeces.

And if you are inside, where do you find a lot of flies?
- kitchen, around food.

Are these the same flies?
- yes, probably.

Flies often walk up walls. How can they do this?
- sticky feet.

So if flies land on rubbish, and have sticky feet and then come in the kitchen, what does this mean?
- Flies bring dirt into the kitchen......Etc.

Teaching questions can also be used to raise people's awareness of problems; for example showing a picture of a dirty kitchen with lots of health hazards and asking how people feel about this picture.

Possible problems

The main problem with question-and-answer is that the health educator may use questions in the wrong way and cause confusion. For example:

If the health educator wants to find out what people's real beliefs and practices are, s/he should not start off by asking testing questions because people will give the answers they think the health educator wants to hear, rather than what they really believe.

Similarly, if the health educator has asked a testing question and someone misunderstands, and gives back a genuine answer that is wrong, the health educator must be careful to avoid giving offence by telling them outright that they are wrong. With teaching questions people may give a correct answer but not the one the health educator wanted, so the session may get sidetracked.

Guidelines for effective use

1. Questions must be clear. The language used must be appropriate (ie technical or English words should be avoided). The level must be appropriate (ie based on people's existing knowledge) and the subject relevant.
2. The health educators should avoid:
   - answering their own questions,
   - rephrasing questions before anyone has had a chance to answer,
   - changing the question halfway through.
   - repeating the question (unless asked to do so).
3. In a large group, the health educator should ask the question, then pause, then indicate the person to answer, either by name, or if the name is not known, then by non-verbal communication such as eye contact, nodding or gesturing in a polite, non-threatening manner. This way, everyone will try to think of the answer. If the person is indicated first, before the question is asked, then everyone who isn't indicated will ignore the question.
4. People should be given enough time to answer; the health educator should be prepared for a few moments silence. If however, everyone shouts at once the health educator should not be alarmed; this is a positive response. The health educator should quieten the group and then indicate the person to answer.
5. The health educators should avoid the temptation to address all questions to just a few people whom they know will answer but should spread the questions around the group. They should be prepared to encourage shyer people, but avoid embarrassing people. If someone doesn't want to answer, that is their prerogative. Adults are not school children. If someone gives the wrong answer the health educator must avoid humiliating them or being scornful (verbally or through non-verbal communication such as tutting).
6. The health educator should try and use questions to guide people towards discovering new knowledge for themselves.
7. After a health talk with a large group, the health educator should stay behind to answer individual questions because people may be reluctant or shy to ask genuine questions in front of a large group.

3.2 HEALTH TALKS

Explanation and meaning

A health talk is a talk given on a specific topic by a health worker aimed primarily at conveying information from the health worker to the audience.

One person, the health worker, does most of the talking.
This is the most commonly used technique for health education; however this does not mean it is the most appropriate. It is used because it is the most familiar method, as it is similar to formal lectures or speeches. It tends to be what both the "teacher" and the "learners" expect in an educational situation.

Reasons for using

To convey information to a group of 5 or more people. However although health workers can convey a lot of information in a health talk, it seldom changes attitudes or practices, only knowledge.

Health workers can plan (and control) the session.

Some people find it easy, mainly because of its familiarity.

Possible problems

It is essentially only one-way communication. The audience remains passive, so they are less likely to remember the information. Even if they remember it, they are less likely to change their attitudes or practices, than if they had been actively involved in the learning process.

Usually health talks end up providing lots of teaching but very little learning. There is no feedback to the health educator, so no assessment of either teaching or learning. However if health talks are the only available method of health education then the following guidelines should help to make them as effective as possible.

Guidelines for effective use

1. Health talks should be combined with other methods (visual aids, question-and-answer, discussion)
2. Maximum length for a health talk is about 15 minutes. It can be longer if there is opportunity for discussion and questions.
3. Maximum number of new points which people can be expected to remember is five. A lot of reinforcement and repetition of the same ideas is necessary. Section 5 contains the most important health messages to convey on various topics.

4. Good preparation is essential:
   - the health educator should find out what the audience (the target group) know/think/do about the topic.
   - the points must be logical and clear.
   - teaching aids (pictures, examples, stories etc) must be carefully prepared.
   - the health educator should practise the health talk beforehand, and time it.
   - the health talk should be given at a time and place which is convenient for both the audience and the health educator.

3.3 DEMONSTRATION

Explanation and meaning

A demonstration involves performing an action or sequence of actions in order to show learners the correct procedure. In a health education session, it should always be followed by then having the learners themselves perform the procedure.
The two stages, the demonstration by the teacher and the return demonstration by the learners, are both essential.

Reasons for using

A demonstration (with a return demonstration) ensures that people are able to immediately put into practice a procedure that they have been taught.
It reveals any problems or misunderstandings.
It reinforces the knowledge. People remember something they have seen and been actively involved in much better than something they have only been told about.
It gives people confidence.
The demonstration (and return demonstration) should be used whenever the health education topic or message includes a practical procedure e.g.

- correct mixture of Oral Rehydration Solution (ORS),
- Cleaning a wound,
- cleaning eyes/applying eye ointment,
- fitting the slab or vent pipe in a pit latrine.

Possible problems

It is time-consuming for everyone to have a turn.
It may need a lot of equipment / supplies.
It is not always completely practicable - e.g., it is not possible for everyone in the group to take turns at fitting the vent pipe in a latrine.
Only a few health education messages include a practical procedure and are therefore suitable for demonstrations.

Very often people think that the practical demonstration is the only important message. For example, people are taught to mix ORS correctly (practical procedure), but do not learn the equally important messages of how much to give, how often and for how long.

Guidelines for effective use

1. A demonstration can be done on a one-to-one basis or with groups.
2. The demonstration must be done correctly and be visible to all the learners.
3. It must use equipment that is appropriate for the target group (ie. locally available, known to them and preferably used in their homes).
4. Before the demonstration, the health educator must check that all the necessary materials are available, and should practise the demonstration beforehand.
5. Not more than 8 steps of procedure should be done at one time; if necessary the procedure can be split into 2 stages.

Suggested procedure for demonstration techniques:

1. The health educator explains reasons for the procedure.
2. The health educator explains the procedure, step-by-step, preferably using a visual aid (for a small group, the real thing should be used; for a large group, an enlarged visual aid should be used).
3. Demonstration by health educator, using real objects and/or people.
4. The learners are given the opportunity to ask questions.
5. The health educator asks one learner (or 2 learners together) to demonstrate while the rest of group watches. (If the procedure is difficult, or, if the first learner makes mistakes, this
   should be repeated until it has been done correctly).
6. The health educator asks the whole group to practise in pairs; this improves confidence, enables them to learn from each other's mistakes, and saves time and materials. The health educator goes round checking and helping pairs who need help.
   If the group is very large (more than 20), groups of 3 should be used instead of pairs.
   If the group is small (less than 8) everyone can do it at the same time rather than working in pairs.
   Having everyone demonstrate one after another should be avoided; this is very time-consuming, and after the first two or three demonstrations becomes very boring.

7. The health educator explains the other important messages related to the demonstration.
8. To finish off, the health educator can ask people in the group to describe the steps of the procedure and the important messages, one learner describing one step and another describing the next step and so on.

For example: mixing Oral Rehydration Solution (ORS) in the home.

Equipment: Salt, sugar, half litre container, bowl and spoon for mixing.

1. Explanation of the importance of ORS to prevent death from dehydration.
2. Explanation of ORS preparation using real objects or a flip chart:

Step 1	Assemble salt, sugar, water, half litre measure, bowl and spoon for mixing.
Step 2	Measure a half litre of water into the mixing bowl.
Step 3	Measure a 3 fingered pinch of salt; add it to the water in the mixing bowl and stir until dissolved.
Step 4	Taste to make sure it is palatable (not saltier than tears).
Step 5	Measure a closed handful of sugar. Add this to the salt and water and mix until dissolved.

3. Demonstration of each step by the health educator.
4. Opportunity for learners to ask questions.
5. Return demonstration by learner(s) in front of the group.
6. Simultaneous practice by all learners in pairs or individually.
7. Explanation of:
   - administration with cup and spoon
   - how much to give
   - how often to give
   - how long to continue
8. Learners describe again all the steps and explanations.

3.4 STORIES

Explanation and meaning

Stories are different from health talks because they have characters and something must happen to them. A good story is entertaining and, therefore, memorable. The audience is interested because they want to find out what happened to the characters. Health information is thus learnt almost subconsciously and therefore probably at a deeper level and more effectively.

Reasons for Using

Stories can be used to give information, to encourage people to look at their attitudes and to help people decide how to solve their problems.
Stories help people to see the health message in a realistic context. They work like an example or explanation.
They are easy to carry around.
They can be passed on to others.

Possible problems

A story may be entertaining but may fail to convey the health message.
People may feel that the story does not apply to them.
Some people may not see the value in a story if it does not contained practical information.

Guidelines for story telling

1. Find or think up stories which are culturally appropriate, so that people can identify with the characters.

2. A story should last only 5-10 minutes otherwise people may become bored or forget parts of the story.

3. Stories should be believable; the characters should have local names and behave like local people. People should be able to identify with them. Scornful or unkind words should be avoided. For example comments like: "the silly man did the wrong thing" should be avoided because people in the audience who have done the same thing may be upset by it.

4. As with health talks, stories must be well prepared. Language must be appropriate and the story teller must behave in a friendly manner. The story should be logical and clear but leave the audience to judge the message and make up their own minds what or who was right or wrong. One good idea is to ask the audience to supply the ending.

5. As with health talks, the story should be followed up with a discussion. This is normally more important than the story itself.
   Questions should be asked to check that people have got the right messages. Encouraging people to think about the story and discuss it, will help them to be involved and to learn from it. For example, ask people what they would do in a situation similar to the story.

3.5 POEMS, PROVERBS AND QUOTES FROM RELIGIOUS BOOKS

Explanation and meaning

In all cultures there are traditional poems, proverbs and religious books. Quotes from these can be very effectively used to reinforce health education messages.

Reasons for using

People are willing to accept the importance and truth of traditional poems, proverbs and especially quotes from religious books, so the messages are more likely to change attitudes and affect behaviour. Also they are usually short and easily remembered.
For example there are Koranic references to the importance of breast feeding babies for 2 years.

> "The mothers shall give suck to their offspring to two complete years." Surat II Baqara; verse 233.

Poems, proverbs and quotes from religious books can relate new health messages to existing beliefs. They can make people feel that the message is important and part of their moral duty.

Like stories they can easily be passed on to others, they should be culturally acceptable, they require no equipment or materials and are easy to transport around.

H E A L T H   E D U C A T I O N

1. I N T R O D U C T I O N

Education for health is one of the eight essential components of primary health care (PHC). It is perhaps the most important component, because it is also a part of all the others and because it promotes community involvement in health care and self reliance.

This chapter explains what health education is and how it should be carried out within the Afghan Refugee Health Programme (ARHP).

2. W H A T   I S   H E A L T H   E D U C A T I O N ?

2.1 Purpose of health education

The purpose of health education is to promote health through improved health practices.

One of the basic principles of PHC is that to improve health, people must be directly involved in taking action themselves, in their own families and communities, to adopt healthy behaviour and ensure a healthy environment.

Health education should inform people not just about facts relating to health but also about their own potential for acquiring better health through their own efforts; this enables people to take responsibility for their own health.

2.2 Changing People's attitudes and practice as well as their their knowledge

Health education is more than just giving information or advice about health. A woman may know that immunizations prevent certain diseases but unless she and her children are fully immunized at the correct time, they will not be protected against these diseases. Health education must change people's behaviour, and this means changing their attitudes and practices as well as their knowledge.

Possible problems

The reference may not match exactly the message which is being conveyed.
Many references can be interpreted in more than one way and can sometimes lead to distracting arguments.

Guidelines for effective use

1. Appropriate poems, proverbs, or quotes from religious books should be found.
2. It is also possible for people to write their own poems.
3. Religious references can be calligraphed to provide a visual aid which then emphasises the authority of the written word.
4. The poems, proverbs and quotes from religious books should be recited in an appropriate way.
5. The relevance of the reference to the health message should be explained or discussed. If the message is not obvious or could be misinterpreted, the message should be explained by the health educator, or, if it is more obvious the learners can be asked for their interpretation.
6. The poems, proverbs and quotes from religious books can also be used after health talks to support the health message.

7. Quotes from religious books must be handled very tactfully. This is especially important if the health educator is a non-Muslim.

3.6 VISUAL AIDS

Explanation and meaning

Visual aids are things that people look at to help them learn, for example: posters, pictures, photos, charts, flip-charts, overlays, flannel graphs, magnet boards, models, real objects. Real objects are always the most effective, and three-dimensional visual aids such as models are more effective than two-dimensional visual aids such as pictures (especially with non-literate village people who are not used to looking at pictures).

A visual aid is an aid to learning, not a complete method in itself. Its effectiveness depends on how well it is used by the health educator.

Reasons for using

Visual aids can support other methods such as talks, discussions, demonstrations, stories.
For many people, a visual impression is more memorable in the long term than words. For example many people remember a picture more easily than a verbal description.
They make the presentation more interesting.
They reinforce the spoken message.
Some things can be explained more clearly in pictures than words (but not everything).
They can provide a focus for discussion.
They can stimulate new ideas.

Visual aids can be used in different ways for different purposes.

i) Initial purpose: to reinforce learning by presenting new ideas through eyes as well as ears - two channels at once.

ii) During the health education session: to act as a memory aid to refer back to. For example, the health educator may show a picture to help explain a message. Later on s/he may refer back to this picture and people are more likely to remember the message and what was said. The visual aid may be left on display throughout the lesson, so that the health educator can refer back to it easily.

iii) After the health education session: seeing a poster on a wall after a health talk may remind people of the message.

Possible problems

If not clear, visual aids can confuse rather than clarify.
They can dominate the session when really it's the learners who should be the main focus.
There is a danger of the health educator talking to the visual aid instead of to the learners.
Visual aids have to be prepared, organized and transported around.
The low level of visual literacy amongst the audience may cause its own problems (see section 2.5).

Guidelines for effective use

> Visual aids are only visual if people can see them. They are only aids to learning if people can understand them.

1. The visual aid must be appropriate for the message, and must relate to the culture and experience of the learners.

2. The health educator must make sure everyone can see the visual aid (with a large group, s/he should check this before the session by standing at the back of the room or teaching area).

3. All the parts in a picture must be explained, especially for non-literate people or rural people who are not often exposed to pictures.
   With a small group, they can be asked questions like: "What do you see in this picture? What do you think this picture is about? What do you think this is (pointing to an object in the picture)?".
   With large groups, it is often better if health educator explains everything difficult in the picture.
   The health educator should avoid asking people to guess what is in a picture unless they are most likely to guess correctly. If, from experience, it is found that certain parts of a picture are usually misinterpreted, these should be explained at the beginning.

4. If possible, the visual aids should be passed around so that people can look at them in small groups and discuss them with each other. Certain kinds of visual aids may be laminated or covered in clear plastic so they do not get damaged or dirty when passed around.

5. Some flip-charts can be used to tell a story, for example by giving the people in them names and creating a story around the pictures.

6. Visual aids can be used to check understanding and memory at the end of a session by asking various people to explain the picture; or this can be done in pairs to check each other's understanding.

7. Pictures or posters can be used as a more permanent memory aid after the health education session by displaying them in an appropriate place where they will be seen again by the audience.

8. When using visual aids which can be displayed on flannel-graphs or magnet-boards, the small pieces should be passed round first, so people can see what they are. This step can be used to get people talking in pairs.

9. Overlaps which are like flipcharts but the sheets are transparent should be built up slowly, making sure each stage is understood before going on. This provides a gradual build-up of a complex picture, instead of sequential presentation (as in a flip chart).

10. The health educator should be aware that flannel graphs are difficult to use under fans or in a wind.

11. When using visual aids which consist of many small pieces, it is necessary to ensure that none of the pieces get lost.

3.7 AUDIO AIDS

Explanation and Meaning

Audio aids are things people can listen to on cassettes or radio, for example: songs, stories, poems, interviews, anecdotes, recorded radio programmes on health topics.

Reasons for using

An audio aid can be useful for gaining people's attention.
It can provide a new and interesting way of presenting information, and may entertain as well as inform.
An audio aid can bring genuine, real life contributions from a range of different people into the health education session.
It can bring in experience and ideas of people who are not present - but still uses their own words and voices.
It provides a voice other than the health educator's and can help to prevent the health educator from dominating the group by doing all the talking himself.
Audio aids can be used to stimulate discussion. They would normally be used with groups rather than one-to-one.

Possible problems

Audio aids require a lot of preparation.
They require some equipment.
There may be technical problems.

Guidelines for effective use

1. Health workers can easily make their own cassettes. For example, they can record an interview with a parent who has successfully used ORT with a child. This can be played back in health education sessions. People will be interested to hear the recording and can identify with the people talking.

2. When the time comes to play the cassette, it is important that everyone in the audience will be able to hear clearly; this will affect the size of the audience and the location.

3. The health educator should explain to people what they are going to hear - who is talking on the cassette, in what situation and what about.

4. With some audio material, it can be very useful to ask people to listen carefully for specific points before playing the recording. One way of doing this is to give 2 or 3 questions and ask people to listen for the answers.

5. The discussion which takes place after playing the cassette is just as important as actually listening to the cassette. The health educator should prepare questions or tasks to start discussions; this can be done either with the whole group or in small groups. This discussion should be conducted in the same way as described in the section on discussion as a health education method (see 3.9).

6. Non-formal uses of audio cassettes are also possible and a good idea. For example, the BHU that plays health education messages for people to listen to while they are waiting in line for medical attention.

3.8 DRAMAS AND PUPPET SHOWS

Explanation and meaning

Dramas and puppet shows are forms of entertainment which can be used to stimulate discussion on health topics. The performance can be enacted by people or puppets. These are a variation on audio-visual techniques but with a stage, props and people or puppets replacing machinery.

Reasons for using

To entertain and inform at the same time.
To stimulate discussion.
To provide an experience that people will remember.
Actors or puppets can express ideas, thoughts, and feelings which may be difficult to express in a more direct, personal situation; for example, objections to using a latrine or having a child vaccinated.
Performances can be fun for the participants as well as the audience.
Materials, if written or adapted by local people, can be much more appropriate and therefore effective than mass-produced audio-visuals such as videos. The messages, characters, language and environment can all be made to fit the local situation and health problems.

Possible problems

Performances require much preparation and rehearsal, and some equipment.
They must be culturally appropriate for the health education to be effective.
Many people are reluctant to participate as actors in front of an audience.

Guidelines for effective use

1. Because of the amount of time and effort to organize, plenty of people should come to see the show. Therefore it should be advertised in appropriate places.
2. If the show is going to take place outside the BHU, in the community, arrangements should be discussed and agreed with the local leaders/elders well in advance.
3. Some people may arrive late. Some introductory activity is useful, for example music, or songs, or some kind of performance by school-children, to allow time for latecomers to arrive and settle.

4. The seating should be arranged so that everyone can see and hear clearly. This can be checked before the show by sitting right at the back and noting whether the stage/screen can be clearly seen or not.
5. The discussion which takes place after the show is just as important, from the health education point of view, as the show itself.
   Therefore it is essential to have some questions prepared for discussion immediately following the show.
   This discussion is best done in small groups, of about 5 people per group (see section 3.9 on discussion).
   After the small-group discussions, one person from each group is asked to report back her/his group's ideas.
   In this way, the watching of the show - which is a personal, individual activity - becomes transformed into a collective educational experience in which the group pools its ideas and opinions. The role of the health educator is that of a manager. He/she organizes, monitors and directs the proceedings, but without dominating people.

3.9 DISCUSSION

Explanation and meaning

In a discussion the talking should be spread equally between all the people in the group, the learners as well as the health educator. This is very important but very difficult to achieve.
The health educator has to lead the discussion without dominating it or allowing anyone else to dominate it.
In order for a genuine discussion to take place the group must be of normal conversational size (ie minimum 2 persons, maximum 5, because beyond 5, groups in natural conversation often split into smaller sub-groups). People should be free from fear of making a fool of themselves, being mocked, or risking humiliation. Also they should share a desire to reach a consensus answer or opinion.

Reasons for using

To enable people to contribute their own experiences and opinions, to reach their own conclusions, and make their own decisions. This process is more likely to lead to changes in attitudes and practices than simply receiving information from a health educator.
There is active involvement of people.
Discussion provides useful feedback to health educator.
It is the most effective way to stimulate group decision-making and action.

Possible problems

It requires considerable skill to lead a discussion without dominating it.
It may be difficult to get people interested and involved.
It may be difficult to keep the discussion relevant.
There can be problems with one or two people dominating the discussion.
It can be difficult to get shy or quiet people to take part.

Guidelines for effective use

1. The whole group should be divided into small groups of 3-5 people. However, there should be not more than 4 small groups, because of time needed to get feedback from them. Therefore, if the whole group is larger than 20 then smaller groups of up to 7 persons can be used.

2. As far as possible, older people should be in different groups from younger people, so that each group is composed of people who would normally interact freely as peers.

3. Groups are given specific question(s) to answer or a task to perform. Each group may be given the same tasks or different tasks. The skill is in selecting or designing tasks which will promote discussion.

   Possible types of task for small group work include:

   3.1 Identification task: for example, the group is given a picture of a home and garden with lots of health hazards. The task is to identify all the hazards and suggest improvements.

   3.2 Comparison: for example each group is asked to compare pictures of two villages and say which they think is healthier to live in and why.

   3.3 Listing: for example, the group has to think of as many different ways of preventing malaria as possible (or protecting water supplies). No visuals are needed for this type of task.

   3.4 Completion task: for example each group has a "starter" set of three things to do when a person has diarrhoea. They have to think of as many more points as they can.

3.5 Classifying: for example, each group has to sort ten different methods of rubbish disposal into those that are safe and those that are dangerous. Picture cards are helpful but not essential.

3.6 Prioritizing tasks: for example, the group has to agree on which of a number of water sources is the safest and which the most dangerous, or what are the 5 most important messages to give to the mother of a child with diarrhoea, etc.

A set of picture cards to arrange in order can help focus this kind of discussion.

A prioritizing task can be used to follow up other tasks, ie the group has to arrange the points in order of importance. In general, prioritizing tasks generate much more fruitful discussion as each participant tries to convince the others of his/her priorities. (During this process of negotiation with the other participants, a subtler process of negotiating the information/ideas also takes place, which produces learning.)

3.7 Ordering tasks: for example, each group is asked to arrange a set of pictures of development of a BCG scar in chronological order.

4. A finishing time should be specified, and each group asked to nominate someone to report back on the group's discussion.

5. Reporters present the results of their group's discussion.

6. The health educator (or a participant) summarises the discussions and the main health messages.

4. TECHNIQUES FOR TRAINING

4.1. Role Plays

Method A: As performances to be watched

Explanation and Meaning

A role play is a learning activity organized by a teacher in which people act out roles in real life situations. Each person acts out their role in the situation, speaking and behaving in the way they think an ordinary person would behave. For example, a role play could be done of a CHW trying to convince a family of why they should build a latrine.

Reasons for using

1) Role plays can require trainees to combine and apply a range of skills and knowledge which they have learned. This is the same as they would have to do in real life situations in their future work.

2) Role plays help to revise and reinforce what trainees have learned.

3) Role plays provide a realistic way of practising skills that involve working with people, which is a major part of a CHW's job.

4) Many people enjoy acting in roleplays once they become accustomed to doing this.

5) People usually find role plays enjoyable and interesting to watch.

Possible problems

1) Some people are shy and don't like to act in roleplays.

2) Roleplays are difficult to control once they have started, even if the teacher is a roleplayer.

3) If roleplays go on for too long they become boring.

4) If roleplayers try to make the roleplays too funny then the people watching may laugh so much that they miss the point of the roleplay.

Encouraging people to change their attitudes and practices requires considerable skill and understanding on the part of health educators. Health educators, themselves, need to understand what people think and do with regard to health problems, and why. They must then use a variety of techniques to help people understand their own situation and problems better and choose actions which will improve their health.

For example, a mother's existing practice may be to feed her child only with breast milk for the first year of the child's life.

The attitudes underlying this practice may include any, or all, of the following:

- fear that other foods will upset the child's stomach,
- unwillingness to do anything differently from local tradition,
- pride in the role of the mother as the sole source of food,
- respect for Koranic instruction about breastfeeding.

The knowledge which underlies this practice is that breast milk is the best food and that feeding children other foods is a difficult and risky business. This information is perfectly true, but it is incomplete. The mother lacks the knowledge that introduction of other foods, though difficult, is essential.

Health education can add to this knowledge by explaining about supplementary foods, why they are important, when they should be started and how they should be given.

This explanation or information alone may not be enough to change the mother's attitude. She may not understand or remember the new information. She may not feel confident to try something new; she may be willing, but be faced with strong opposition, scorn or criticism from older relatives. The child itself may reject the new foods.
So she will not change her practice.

In such a case the attempt at health education has not been successful.

In order for health education to be successful, people must:

- understand the health education messages,
- believe the health education messages,
- perceive how the messages relate to their needs,
- remember the health education messages,
- change their attitudes
- and then put the new ideas into practice.

5) Trainers often confuse the practice of a practical skill, e.g. making O.R.S., with roleplay. Practice after a demonstration is not a roleplay. If trainers try to include a complicated practical task in role play then the roleplay may become too long.

Guidelines for effective use

1) Decide what topics can be taught or revised using roleplay.

2) Plan the content of the roleplay carefully so that the roleplay does not exceed 10 minutes.

3) Early on in the training select people for roleplays who will not be shy or embarrassed. Later on, involve the quieter trainees in roleplays as well.

4) Prepare and, if possible, practise the roleplay with the roleplayers in advance.

5) A few simple aids (props) to help the acting makes the roleplays much more effective e.g. doll, ORS packet.

6) If appropriate, direct the group's attention to the main points of the roleplay before starting. This can be done by asking one or two questions related to the roleplays which the trainees have to answer after the roleplay.

7) Do not allow interruptions during the roleplay. This applies to the trainer as well as the trainees.

8) After the roleplay, ask the roleplayers about their opinions and feelings from the roleplay. This also allows them an opportunity to correct any mistakes which may have been made.

9) Discuss the roleplay with the group. This discussion would include getting answers to any questions that may have been given.

10) Summarize the main points from the roleplay.

11) If appropriate, repeat the roleplay with different roleplayers.

Method B: As small group activities

Explanation and meaning

The meaning of roleplay is the same as in Method A. The use here is different however. Instead of a few participants acting the roleplay while the rest watch all the participants act out roleplays at the same time. For this to be possible the participants must be divided into small groups. Each group may have the same roleplay or each may be given a different roleplay.

Reasons for using

1. Reasons 1 to 4 of Method A apply.

2. The fact that no people are watching helps even shy people to get involved in their roles.

3. This use of roleplay can be especially useful for all participants to experience the influence of attitudes on behaviour. They can also try out different ways of trying to change people's attitudes and behaviour.

Possible problems

1. The different groups may finish their roleplays at different times. This can create organizational problems for the trainer.

2. Designing roleplays that will succeed in getting people fully involved in their roles is difficult.

3. More roleplay aids are required than Method A.

Guidelines for effective use

1) Decide what topics can be taught or revised using this roleplay method.

2) Design a roleplay which depicts a realistic problem for which the roleplayers must negotiate a solution between themselves. Each roleplayer must be given a specific point of view on the problem. The role should be designed so that a compromise solution can be eventually reached by the roleplayers.

For example, a roleplay on vaccination may have the following roles:

a) Parent who is afraid his/her child will get ill after a vaccination.
b) Grand parent who believes that diseases are the will of Allah.
c) Vaccinator or CHW.
d) Neighbour whose first child died from measles and who has since had all of his children vaccination.

3) Divide participants into groups of the appropriate size.

4) Having discussion topics ready for each small group to start on as they finish their roleplays can solve the problem of groups finishing at different times.

5) Summarize the main points from the roleplays.

4.2. Field visits

Explanation and meaning

Field visits are activities which take trainees out of their normal place of training to learn in the community. For example, visiting BHU or another project, seeing some wells or latrines, seeing unhygienic or unhealthy places in the community.

Reasons for using

Field visits enable trainees to learn from what is happening in the community and places or organizations which are relevant to their work. they can also help trainees to apply what they learn in a training course. This reinforces what they have learned and at the same time enables trainees to see the practical application of what they are learning.

Possible problems

Field visits to see things in the community can attract crowds which may be off-putting for some trainers. Field visits need careful preparation and sometimes transport. Field visits often need lots of time. This may be difficult to fit into a lesson or course timetable. Weather can also be a problem.

Guidelines for effective use

The trainer should:

1) decide on what topics can be taught or reinforced by appropriate field visits;

2) decide exactly what the trainees should learn from a field visit;

3) decide how the trainees will learn this from field visit;

4) make all necessary arrangements for the field visit well in advance; this includes information all the people involved such as transport staff, community members, project staff and the trainees;

5) estimate approximately how much time will be needed for the field trip;

6) explain in advance to any workers who the trainees will be visiting, what the trainees should learn from the visit and what the workers should do with the trainees; the trainer should remember that people have their own work to do, so should not ask for too much;

7) explain to the trainees the purpose of the field visit, what they should do and any special points about the visit;

8) provide opportunities for the trainees to actively participate in the field visit; for example, by asking them questions or giving them some assignment related to the field visit; It may be desirable to divide a class into smaller groups;

9) avoid sending trainees on a visit to a BHU or a project without adequate supervision or preparation;

10) remember that people who cooperate with a field visit are giving their time and effort to help trainees; they should always be thanked at the end of a visit (especially if the visit is likely to be repeated);

11) follow up the field visit by discussing the visit with the trainees and summarizing the important points that they should have learned.

4.3. Audio Visual materials

Explanation and meaning

Audio-visual materials are those which combine both audio and visual means of communication. People both watch and listen to them. Examples are films, videos and slide shows with accompanying tape recording.

Reasons for using

To entertain and inform at the same time.
To stimulate discussion.
To provide an experience that people will remember.
To present complex information or ideas in a clear, simple and memorable manner.
To show real life examples of good health practices in similar communities.

Possible problems

1. A lot of equipment is necessary which is often not readily available.

2. The health educator must know the materials well and this takes time and preparation.

3. Preparing the equipment, materials and location before the session also takes considerable time and effort.

4. Some source of electricity is needed. Power failures and other technical problems can arise.

5. The materials may not be culturally appropriate.

Suggestions for effective use

1. Because of the amount of time and effort to organize, enough people should come to see the show but not too many. Therefore, it should be advertised in appropriate places.

2. If the show is going to take place outside the BHU, in the community, arrangements should be discussed and agreed with the local leaders/elders well in advance.

3. All materials/equipment must be available and in working order well before the show is due to start, with spare batteries/fuses/bulbs for electrical equipment.

4. The seating should be arranged so that everyone can see and hear clearly. This can be checked before the show by sitting right at the back and noting whether the stage/screen can be clearly seen or not.

5. Before starting explain what the show is about.

6. It may be useful to focus people's attention on the basic ideas running through the show by asking 2 or 3 "focus" questions before starting. People try to learn the answers while watching the show. The answers are then discussed by the group afterwards.

7. Regardless of whether or not "focus" questions have been asked, a discussion should be held after the show. The discussion which takes afterwards can be just as important, from the health education point of view, as the show it self.

   Therefore it is very helpful to have some topics prepared for discussion following the show. This discussion is best done in small groups, of about 5 people per group.

   After the small-group discussions, one person from each group is asked to report back her/his group's idea. In this way, the watching of the show - which is a personal, individual activity - becomes transformed into a collective education experience in which the group pools its ideas and opinions. The role of the health educator is that of a manager. He/She organizes, monitors and directs the proceedings, but without dominating people.

<u>Summary of procedures for using audio-visual aids</u>

1. Introductory activity (with or without "focus" questions).

2. Show audio-visual material (followed by checking answers of "focus" questions if asked).

3. Small-group discussion.

4. Representatives of the small groups report their group's views to the whole group.

5. Concluding discussion.

5. CONTENT OF HEALTH EDUCATION

5.1 Relevant, practical, appropriate, positive

The previous section dealt with how to deliver health information to the community, this section will be concerned with what should be the health information conveyed to the community.

Health information should be:

- relevant: For example, there is no need to discuss ways in which the community may reduce risk of malaria if malaria is not a problem in the RV.

- practical: For example, encouraging mothers to give their children meat and eggs would not be practical or appropriate if both were so expensive for the family's budget or if they were not readily available.

- appropriate: For example, health education messages need to be culturally appropriate and not conflict with deeply held beliefs.

- positive: Health information should be positive and state what should be done to promote good health and prevent disease. In general, negative messages "don't do ...." should be avoided.

5.2 Messages

A convenient way for the health educator to summarize health information is in the form of messages. An example of a message is:
'Mothers should start to breast feed their babies immediately after birth.' This message is simple, practical and appropriate and if the health worker is conducting a session on breast feeding, this is one of the messages that the audience should take away with them.

Although this is a simple message, the reasons for the message may be several. In this case:

- Starting to breast feed immediately after birth stimulates the production of breast milk. If possible, breast feeding should begin not later than one hour after the delivery of the baby.

- In some countries, mothers are advised not to feed their babies on the thick yellowish breast milk (called colostrum) which is produced in the first few days after the birth. This advice is wrong. Colostrum is good for babies and helps to protect them against common infections. The baby does not need any other foods or drinks while waiting for the mother's milk to 'come in'.

5.3 Priority topics/messages

Within the refugee health programme some health strategies are considered more important than others. For example, priority has been given to interventions which prevent children from dying or

developing severe illness, such as immunization, control of diarrhoeal diseases and management of acute respiratory infections.

Within the refugee health programme, the following topics have been given special priority. Lists of prime messages for these topics for health education have been developed or are in preparation:

- Child growth
- Immunization
- Breast feeding
- Control of diarrhoeal diseases
- Personal hygiene and sanitation
- Acute respiratory infections and tuberculosis
- Maternal care
- Malaria

These topics reflect the major health needs and problems of the refugees and are considered to be of the highest priority for 1989.

However the health needs and priorities may vary from district to district and health personnel along with the community must decide what is most relevant for that community.

5.4 Child growth

The prime messages are:

- Breast milk alone is the best possible food for the first 4 months of the child's life.

- By the age of 4 months, the child needs other foods in addition to breast milk.

- By the age of 1 year, the child needs to eat at least 4 times a day.

- By the age of 1 year, the child should eat all the foods the family eats, made soft.

- During and after an illness a child needs extra food and extra meals.

- Children between the ages of birth and upto 2 years of age should be weighed regularly. If there is no weight gain for 2 months, something is wrong.

5.5 Breast feeding

The prime messages are:

- Breast-milk alone is the best possible food and drink for a baby
  in the first 4 months of life.

- Babies should start to breast feed immediately after birth.

- Breast feeding should continue up to 2 years of age.

- Never use bottles as bottle feeding can lead to serious illness and death.

- Continue breast feeding during the next pregnancy.

- A mother who is breast feeding should eat for two persons.

- Breast feeding should be stopped slowly.

5.6 Immunization

The prime messages are:

- A child who is not vaccinated is more likely to become sick, disabled and die.

- Childhood vaccination protects against six dangerous diseases: polio, measles, whooping cough, diphtheria, TB and tetanus.

- All vaccination must be started as soon as possible after birth and should be completed in the first year of the child's life.

- Every woman should be fully vaccinated against tetanus to protect both herself and her babies from tetanus.

- It is safe to vaccinate newborn babies, sick children, and pregnant women.

- Vaccination cards are important. They must be kept safely by the family. They should be brought with the woman and child on every visit to the clinic or health worker.

- Infants must complete the full course of vaccination, otherwise the vaccine may not work.

- After vaccination the child may develop a fever or rash or a small sore. These are not dangerous problems and parents should not worry about them.

5.7 Control of diarrhoeal diseases

The prime messages are:

- Diarrhoea can kill children by draining too much liquid from the body.

- Give a child with diarrhoea extra fluids frequently as soon as it begins and as long as it continues.

- When a child has diarrhoea, it is important to continue breastfeeding.

- A child with diarrhoea needs food. Bottle feeding and soothers are bad and lead to diarrhoea.

- Trained help is needed if diarrhoea is more serious than usual.

- After diarrhoea stops, a child needs extra food every day for at least a week.

- Medicines other than ORS should not be used for diarrhoea, except on medical advice.

Traditional teaching methods tend to emphasize telling people new information. These are based on the methods commonly used in teaching children in schools. But teaching adults is fundamentally different from teaching children because adults already have much more life experience and this has formed their existing knowledge, attitudes and practices. Health education with adults is about changing existing health behaviour and not just teaching some new facts.

Therefore health education requires a very different approach to teaching and also a greater understanding of people. Section 3 covers some different teaching methods which can be used to make health education more effective.

2.3 How people learn

Most knowledge, attitudes and practices relating to health are not learnt through the formal education system (ie at school) - indeed, most Afghan women and a lot of the men have never been to school.

People learn from many other people as well as teachers, and people learn in many other situations as well as formal lessons.

These are some of the ways in which people learn:

- their own experience
- observation
- thinking
- solving problems that arise in everyday life
- formal lessons
- making mistakes and realizing what they did wrong
- reflecting on past experience
- adapting past experience to new situations
- listening to other people
- reading books, newspapers, magazines and instruction leaflets
- listening to the radio
- watching TV and videos

These are some of the people they learn from:

- parents
- other family members
- friends
- teachers
- people observed in the community
- colleagues at work
- elders in the community

- The following can help prevent diarrhoea: breast feeding, using latrines, keeping food and water clean and covered, washing hands before touching food, washing hands after using latrine.

5.8 Personal hygiene and environmental sanitation

The prime messages are:

- Faeces contain microbes which cause diseases.
- People can swallow these microbes if the microbes get into water, onto food, and onto hands.
- Diseases can be prevented by washing hands with water and soap after defecation and before touching food.
- Diseases can be prevented by using safe, clean latrines.
- Diseases can be prevented by using safe, clean water for drinking.
- Diseases can be prevented by regular washing of the body and clothes.
- Diseases can be prevented by keeping food clean.
- Diseases can be prevented by burning or burying household refuse
  and proper disposal of waste water.

5.9 Acute Respiratory Infections and Tuberculosis

The prime messages are:

Tuberculosis

- Tuberculosis is spread by air when a person with pulmonary tuberculosis coughs or spits.
- People should cover their mouth when they cough.
- People should spit into a spittoon.
- Persons with cough, chest pain or blood in the sputum should go to the BHU repeatedly for a sputum check.

- Treatment of TB is very long.

- Treatment must continue even after symptoms have gone.

- Only treatment taken regularly every day cures TB patients and stops the infection from spreading to others.

Acute Respiratory Infections

- If a child with a cough is breathing more rapidly than normal, the child is at risk and medical attention should be sought immediately.

- A child with a cough or cold should be helped to eat and to drink plenty of fluids.

- Children that are breast fed, well nourished and fully immunized are less likely to get pneumonia.

5.10 Maternal care

The prime messages are:

- The risks of child birth can be reduced by going to the health worker for check ups during pregnancy.

- All women should receive immunization for tetanus prior to delivery.

- A trained person should assist at every birth.

- A woman needs more food during pregnancy unless she is already over-weight.

- Spacing pregnancies at least 2 years apart and avoiding pregnancies below 18 and above 35 years greatly reduces the dangers of child bearing.

- All women need iron supplementation during pregnancy and for at least 1 month after delivery.

5.11 Malaria

The prime messages are:

- Malaria is transmitted by mosquitoes. Mosquitoes can be killed by insecticide spray on walls of houses.
- Everyone especially children should be protected from mosquito bites especially at night.
- People should destroy mosquito eggs and prevent mosquitoes from breeding.
- Children and adults with a fever should go to the BHU for a blood smear to be taken.
- If malaria is the cause of the fever, the person must complete the full course of the anti-malaria drugs.

6. HEALTH EDUCATION IN SCHOOLS

6.1 Introduction

If health education is taught to children throughout their childhood this will enable them to develop good health practices, both for the present and also hopefully the future.

Children can receive health education from three main sources:
1. Parents and relatives in the home.
2. Community leaders, mullahs and health workers in the community.
3. Teachers in the schools.

Health education in schools should not be done in isolation from the home or community. If links are made between health education in the school, home and community, then health messages will be reinforced. In this way real improvements in today's children's health, and the health of future generations, can be expected.

6.2 Reasons for health education in schools

1. Health education should enable school children to develop good health practices based on a rational understanding of the causes of diseases and receive practical advice which will be of direct use in their own situation.
2. Many school-aged children are involved in looking after their younger brothers and sisters. They are therefore in a position to directly apply the health education messages.
3. School-aged children can also teach health education messages to their younger brothers and sisters.
4. As future parents, school children need good health practices in order to be able to care well for their own children when the time comes.
5. As the future educated members of the community, school children will be in a good position to act as agents for change in the improvement of the community's health attitudes and practices.

6.3 Suggested Curriculum

In many Afghan primary schools only 3 subjects are taught in the first three grades: Maths, Pushtu and Islamiat. If a school has classes from Grade 4 upwards then science is often taught, this subject sometimes includes health education. Most children do not stay in school beyond Grade 5, so the connection between maintaining ones' health and environmental sanitation must be established in the first 3 grades.

In view of this, the following health education curriculum may be most appropriate:

Grades 1,2 and 3:-	Health education integrated with the teaching of Maths, Pushtu and Islamiat by the teachers of these subjects.
Grades 4 and 5:-	Health education taught as part of science by the teacher of this subject. Integration of health education with Pushtu and Islamiat can continue.

Suggested topics.

- How sickness is caused and spread.
- Personal hygiene.
- Water.
- Sanitation (home and community)
- Flies.
- Common health problems.
- Diarrhea and Oral Rehydration Therapy (ORT).
- Malaria
- How to care for a sick child.
- Vaccination
- Food
- Accidents
- First Aid.

It is essential that the topics and health messages taught to a particular grade are within the mental capabilities of children of that age. For example, children in grade 1 or 2 may be able to understand about giving fluids to sick children, but may not be able to understand how to make ORT until grade 3 or 4.

It is also important that the order in which topics are taught is carefully considered. One lesson should follow on from previous lessons in such a way that children's understanding of health messages becomes more detailed and broader as they continue their schooling. For example the importance of latrines should be taught after teaching that faeces can cause sickness, but before teaching about how to use a latrine correctly. Different lessons should be related to each other so that children can gradually build up a complete health picture.

6.4 Teaching and learning

Because of the way they were taught, many teachers assume that teaching means "telling". So teachers spend most of their time talking at children who have to memorize what they are told. Just giving a talk is usually not a very good method of teaching.

Most methods discussed in Sections 3 and 4 can be used in schools. In particular, demonstration, question-and-answer, stories, poems, proverbs and quotes from religious books, visual aids, puppet shows, dramas and in higher grades, roleplays can be very effective in helping children as well as adults learn.

Generally, children learn best if:-

1. They are actively involved in the lesson.
2. Their lessons are related to previous and subsequent ones.
3. They can understand how the health messages are linked to their life at home and in the community.

Children are often more curious and open to new ideas and approaches than adults. Therefore, the teacher working with children can use activities which are very effective in stimulating learning but which might be regarded by adults as not sufficiently serious.
For example, after reading to school children a story with a health education message, the following activities could be carried out:

- ask the children to write a play based on the story.
- show the children how to make simple hand puppets.
- the children can use the puppets to act out the play (thus reinforcing the health message).
- arrange for the children to present their puppet show to other classes of younger children in the school (or in other schools).

This requires a commitment to teacher training and the provision of sufficient, appropriate educational material.

School teachers have often had little or no formal training. It is unreasonable to expect them to be able to teach health education (or any other topic) effectively without help. A school health education programme which emphasizes teacher training is preferable to one where "outside" health education teachers come and teach health education directly with little time for the school teacher or follow up.

One very practical way of linking health messages to life at home is by using "Child-to-child" activities in teaching health education. These activities encourage school children to pass on and use the health education they learn to younger brothers and sisters at home and to children who do not go to school. The "Child-to-child" references best explain this approach to teaching health education.
Examples of the child-to-child activity sheets are attached in the appendix.

7. USEFUL REFERENCE MATERIALS

1.

1. Education for health: manual on health education and primary health care. WHO.
2. Teaching health care workers: a practical guide. Fred Abbatt and Rosemary McMahon.
3. Teaching for better learning. Fred Abbatt.
4. Facts for life: WHO/UNICEF
5. Helping Health Workers Learn: David Werner, Bill Bowers.

2. Health Education in schools

1. Primary health education: Young and Dustman (Longman)
2. Child to child: Arron and Hawes Macmillan
3. Child to child activity sheets.
   Available from: The Child to Child Programme
   Institute of Child Health
   30, Guildford St,
   London, WE1N1EH, England

Formal lessons given by teachers are only one of a wide range of situations in which people acquire new knowledge, skills and attitudes.

This point needs to be reflected in our health education practice:

- participants can learn from discussion with each other as well as from the health educator
- they can learn from the materials, visual aids, etc, as well as the health educator talking.
- they can learn by relating the new ideas to their own experience, and by discussing the ideas with people at home and in their community. Health education does not end when the formal health education session ends.

There is an ancient Chinese proverb which is very relevant to health education.

I hear and I forget;
I see and I remember;
I do and I understand.

As an example of this consider teaching someone to make up ORT.

- someone who is just told how to make up ORT will probably forget.
- someone who is told and watches a demonstration is more likely to remember how to make up ORT.
- someone who also makes ORT up themselves, is much more likely to understand how to do it and be able to do it again.

The more actively involved people are in something the more likely they are to understand and remember it and be able to do it.

However it is not always possible to demonstrate a health message and let people actually do it in practice. But it is possible to actively involve people in learning by:

- discussing ideas with them,
- listening to their opinions, experiences and questions,
- providing them with materials and activities which will help them to discover new information for themselves.

2.4 Communication

One-way and two-way communication

The effective communication of health education messages depends on an exchange of ideas between the health educator and the learners. This is called two-way communication. It involves the health educator:

- encouraging learners to explain what they already know and do,
- giving the learners the opportunity to ask questions,
- fully answering the learners' questions,
- giving opportunity for the learners to discuss new ideas amongst themselves,
- finding out what the learners have understood and learnt from the session.

Some teachers feel that they must do all the talking themselves. They feel that they are not really teaching unless they are telling the students some new information. But this is one-way communication. This is not appropriate for health education.
The main emphasis in this type of teaching is on the teacher, who decides what the student should learn; the student passively receives the knowledge.

In health education two-way communication is essential in order for the learners to be actively involved. The teacher's role is to guide learners to develop their own knowledge, skills and attitudes, rather than just acquiring the teacher's. This process involves people in making their own decisions and can therefore result in behavioral change.
This is not traditional teaching but the promotion of learning; it places the main emphasis on the learner and involves two-way communication between the teacher and the students.

Verbal and non-verbal communication

Attitudes and feelings are often conveyed in gestures, not in words; this is non-verbal communication.

In health education, non-verbal communication is used in many ways, both positively and negatively, and intentionally and unintentionally.

Positive examples would be:

- smiling or eye-contact, indicating approval and interest,
- sitting down with a group to discuss something with them can express non-verbally the feeling of being on the same level, and not superior to them,
- greeting people according to their traditions.

Negative examples would be:

- yawning can express boredom and the feeling that the person's time is being wasted;
- not looking at the person being talked to, can also do the same thing in a more subtle way;
- tutting, shaking the head or wagging a finger can all express dissatisfaction non-verbally.

People are generally very sensitive to non-verbal communication, and health educators in turn need to be sensitive to this and be aware of how and what they are communicating in this way.

An extension of this is "practising what you preach". The health educator who tries to motivate people to use soap to wash hands before a meal and then promptly eats food without washing his hands with soap, conveys the message that he feels that soap is not really necessary. It is extremely unlikely in this situation that other people will be convinced that it is necessary for them! The health educator should be an example for the learners.

2.5 Literacy

Literacy is the ability to read and write. Literacy is not an indication of intelligence, or of knowledge. It only indicates that the person has had the opportunity to go to school. People who are not literate may be highly intelligent, and often have very good memories. They deserve as much respect from the health educator as literate people. They should not be treated as stupid.

However as they cannot write and read, writing cannot be used to help them to remember information given in the health education session. Therefore, in order to help people remember, health education messages must be:

- limited in number, and
- repeated frequently.

Pictures and visual aids have to be "read" in a similar way to ritten words. People who have not seen many pictures may not be able to relate a picture to the object it represents. Also many pictures use conventions to represent real things. For example, a health worker showed a poster-sized picture of a fly, and explained how flies spread diseases. At the end of the session, one of the audience said that the talk was very interesting but luckily they did not have that problem in their village because they only had small flies there.

Pictures may also use symbols that do not really look like the object they represent, for example, a circle with spikes sticking out to indicate the sun shining. Again people may have difficulty understanding this. Even more difficult are symbols like ticks and crosses to represent good and bad, or "do" and "don't".

However, if the health educator explains them carefully, people can learn to "read" pictures during the health education session. But very few pictures convey messages successfully without explanation to non-literate people.

When using visual aids, the health educator needs to:
- be aware of these possible problems,
- learn how to look at visual aids from the point of view of someone to whom they are new,
- explain the content and meaning of pictures to people.

The use of visual aids is explained in more detail in section 3.6.

2.6 Helping people learn

There are some general points which the health educator should be aware of when teaching.

People learn better if:
- they are learning about something which interests them and is important and relevant to them.
- the new knowledge builds on their existing knowledge, and does not conflict with deeply held beliefs.
- the new information is presented logically and makes sense.
- the new information is presented in a relaxed atmosphere, without distractions or interruptions
- the new information is presented by someone they respect and feel they can trust.

All adults have a lot of experience of life. They already have developed their own ideas about health; also, they may be much older than the health educator. The health educator needs to be respectful, patient and tactful.

2.7 Situations for health education

Health education may take place in a lot of different situations, for example:
- home visits
- clinic consultations
- scheduled talks to small groups - at the clinic
  - in the community
- meetings with large groups - at the clinic
  - in a mosque
  - in schools

The health educator may be working with people in any of the following ways:
- one to one,
- one-to-one but with others listening,
- with small groups of 3 to 5 people,
- with groups of 5 - 20 people,
- with a large meeting of more than 20 people.

The health education may be:
- with a person who is ill, and needs help on management of the illness,
- with a person who is not ill and needs motivation to prevent illness,
- with a group of people who need help in putting into practice a health-promoting project such as environmental sanitation.

All of these, and many other, situations require the health educator to use different techniques. These are dealt with in more detail in the next section.

2.8 The difference between education and training

In these guidelines, health education is used in the sense of learning by members of the community. Each 'session' stands on its own and is not necessarily part of a course. The participants are not selected, anyone in the community may attend. Participants are likely to be different at each session.

Training, on the other hand, refers to a scheduled series of inter-related sessions attended by the same participants on each occasion. For example, courses for CHWs, dais, sanitation workers, dispensers etc. Participants are selected for training according to particular criteria and are expected to attend sessions regularly. Training is therefore, more formal and organized, while health education in the community is non-formal.

The techniques described in these guidelines are divided into two groups. The first group, Section 3: Health education techniques, comprises techniques which are appropriate for health education in the community.

The second group, Section 4: Techniques for training, consists of techniques which are primarily applicable in training situations. However, many techniques from the first group are also important in training.

It should be noted that these guidelines are directed primarily towards health education and training with non-literate or semi-literate people.

Afghan Refugee Health Programme
Pakistan

Guidelines

Health Education

Chief Commissionerate Afghan Refugees
United Nations High Commissioner for Refugees

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HEALTH EDUCATION

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